COMMUNIT' DIAGNOSTIC AND TREAT 'ENT CENTER
A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300
Cincinnati, Ohio 45202
Phone: (513) 651-9300
Fax: (513) 352-1345

September 1, 1994

Bethesda Hospital
Attn: Dr. Schwartz
619 Oak Street
Cincinnati, Ohio 45206

RE: Lee Moore DOB: 10-19-74

TO WHOM IT MAY CONCERN:

Enclosed is a signed Authorization for Release of Information form regarding the above-named person.

Our agency is under a very strict time-frame to provide a comprehensive report to the Court, therefore, we would greatly appreciate information from you as soon as possible.

Thank you in advance for your prompt and courteous attention to this matter.

Sincerely,

Jenny O'Donnell, B.S.
Psychology Trainee

CC 0341

CENTRAL PSYCHIATRIC CLINIC
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON Dr Schwartz @ Bethesda 1991 or 92

ADDRESS 619 Oak St.; 45206

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR _____

The following information may be released or reviewed:

(✓) Discharge Summary
(✓) Face Sheet with Final Diagnosis
(✓) Complications & Operative Procedures
(✓) History and Physical
(✓) Consultative Report(s)
( ) Inpatient (✓) Outpatient

(✓) Reports of Tests or X-rays
(✓) Emergency Treatment(s)
( ) Outpatient Clinic Notes
Specify Clinic: _____
( ) Other Medications ?
( ) Emergency Department

This Authorization for Release of Information may be revoked by me at any time with written notice to the parties involved, except to the extent action has been taken prior to revocation. This Authorization for Release of Information will expire ninety (90) days after date below, or sooner by my choice, in which case this consent will expire on _____.

I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Moore X Lee E. Moore Jr.
(Signature of Client)

Date of Birth 10-19-74

Social Security No. 284-74-1946 9-1-94
(Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell
Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by _____
(Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

CC 0342

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300
Cincinnati, Ohio 45202
Phone: (513) 651-9300
Fax: (513) 352-1345

September 2, 1994

Central Baptist School
Attn: School Records
7645 Winton Road
Cincinnati, Ohio 45214

RE: Lee Edward Moore DOB: 10-19-74

TO WHOM IT MAY CONCERN:

Enclosed is a signed Authorization for Release of Information form regarding the above-named person.

Our agency is under a very strict time-frame to provide a comprehensive report to the Court, therefore, we would greatly appreciate information from you as soon as possible.

Thank you in advance for your prompt and courteous attention to this matter.

Sincerely,

Jenny O'Donnell

Jenny O'Donnell, B.S.
Psychology Trainee

CC 0343

CENTRAL PSYCHIATRIC CLINIC
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON Central Baptist School Attn: School Records

ADDRESS 7645 Winton Road, (14)

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR _____

The following information may be released or reviewed:

( ) Discharge Summary
( ) Face Sheet with Final Diagnosis
( ) Complications & Operative Procedures
( ) History and Physical
( ) Consultative Report(s)
( ) Inpatient ( ) Outpatient
( ) Reports of Tests or X-rays
( ) Emergency Treatment(s)
( ) Outpatient Clinic Notes
Specify Clinic: _____
(✓) Other All Records
( ) Emergency Department

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I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Moore Middle (Edward) Lee E Moore Jr.
(Signature of Client)

Date of Birth 10-19-74

Social Security No. 284-74-1946 9-1-94
(Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell
Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by Jenny O'Donnell
(Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

CC 0344

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER

A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300
Cincinnati, Ohio 45202
Phone: (513) 651-9300
Fax: (513) 352-1345

September 2, 1994

South Junior High School
Attn: Medical Records
1917 Miles Road
Cincinnati, Ohio 45231

742-0666

RE: Lee Edward Moore DOB: 10-19-74

TO WHOM IT MAY CONCERN:

Enclosed is a signed Authorization for Release of Information form regarding the above-named person.

Our agency is under a very strict time-frame to provide a comprehensive report to the Court, therefore, we would greatly appreciate information from you as soon as possible.

Thank you in advance for your prompt and courteous attention to this matter.

Sincerely,

Jenny O'Donnell, B.S.
Psychology Trainee

CC 0345

CENTRAL PSYCHIATRIC CLINIC
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON Adk. South Junior High School (Mt. Healthy)

ADDRESS 1917 Miles Rd; (31)

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR _____

The following information may be released or reviewed:

( ) Discharge Summary
( ) Face Sheet with Final Diagnosis
( ) Complications & Operative Procedures
( ) History and Physical
( ) Consultative Report(s)
( ) Inpatient ( ) Outpatient
( ) Reports of Tests or X-rays
( ) Emergency Treatment(s)
( ) Outpatient Clinic Notes
Specify Clinic: _____
(✓) Other All Records
( ) Emergency Department

This Authorization for Release of Information may be revoked by me at any time with written notice to the parties involved, except to the extent action has been taken prior to revocation. This Authorization for Release of Information will expire ninety (90) days after date below, or sooner by my choice, in which case this consent will expire on _____.

I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Middle (Edward) Moore ✓ Lee E. Moore Jr.
(Signature of Client)

Date of Birth 10-19-74

Social Security No. 284-74-1946 9-1-94
(Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell
Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by _____
(Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

CC 0346

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER

A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300
Cincinnati, Ohio 45202
Phone: (513) 651-9300
Fax: (513) 352-1345

September 2, 1994

Talbert House for Young Men
Attn: Records
1105 East McMillan
Cincinnati, Ohio 45219

RE: Lee Moore DOB: 10-19-74

TO WHOM IT MAY CONCERN:

Enclosed is a signed Authorization for Release of Information form regarding the above-named person.

Our agency is under a very strict time-frame to provide a comprehensive report to the Court, therefore, we would greatly appreciate information from you as soon as possible.

Thank you in advance for your prompt and courteous attention to this matter.

Sincerely,

Jenny O'Donnell/JP

Jenny O'Donnell, B.S.
Psychology Trainee

CC 0347

CENTRAL PSYCHIATRIC CLINIC
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON Talbert House for Young Men

ADDRESS 1105 E. McMillan, (19)

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR _____

The following information may be released or reviewed:

( ) Discharge Summary
( ) Face Sheet with Final Diagnosis
( ) Complications & Operative Procedures
( ) History and Physical
( ) Consultative Report(s)
( ) Inpatient ( ) Outpatient

( ) Reports of Tests or X-rays
( ) Emergency Treatment(s)
( ) Outpatient Clinic Notes
Specify Clinic: _____
(✓) Other EVALUATION RECORDS
( ) Emergency Department

This Authorization for Release of Information may be revoked by me at any time with written notice to the parties involved, except to the extent action has been taken prior to revocation. This Authorization for Release of Information will expire ninety (90) days after date below, or sooner by my choice, in which case this consent will expire on _____.

I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Moore X Lee E. Moore Jr.
(Signature of Client)

Date of Birth 10-19-74

Social Security No. 284-74-1946 9-1-94
(Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell
Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by Jenny O'Donnell
(Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

CC 0348

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER

A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300
Cincinnati, Ohio 45202
Phone: (513) 651-9300
Fax: (513) 352-1345

September 2, 1994

Woodward High School
Attn: Records
7001 Reading Road
Cincinnati, Ohio 45237

RE: Lee Moore DOB: 10-19-74

TO WHOM IT MAY CONCERN:

Enclosed is a signed Authorization for Release of Information form regarding the above-named person.

Our agency is under a very strict time-frame to provide a comprehensive report to the Court, therefore, we would greatly appreciate information from you as soon as possible.

Thank you in advance for your prompt and courteous attention to this matter.

Sincerely,

Jenny O'Donnell, B.S.
Psychology Trainee

CC 0349

CENTRAL PSYCHIATRIC CLINIC
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. **PROHIBITION ON REDISCLOSURE:** Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON Woodward High School Records Dept.

ADDRESS 7001 Reading Rd.; (37)

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR _____

The following information may be released or reviewed:

( ) Discharge Summary
( ) Face Sheet with Final Diagnosis
( ) Complications & Operative Procedures
( ) History and Physical
( ) Consultative Report(s)
( ) Inpatient ( ) Outpatient
( ) Reports of Tests or X-rays
( ) Emergency Treatment(s)
( ) Outpatient Clinic Notes
Specify Clinic: _____
(✓) Other ALL RECORDS
( ) Emergency Department

This Authorization for Release of Information may be revoked by me at any time with written notice to the parties involved, except to the extent action has been taken prior to revocation. This Authorization for Release of Information will expire ninety (90) days after date below, or sooner by my choice, in which case this consent will expire on _____.

I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Moore Lee E. Moore Jr.
(Signature of Client)

Date of Birth 10-19-74

Social Security No. 284-74-1946 9-1-94
(Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell
Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by Jenny O'Donnell
(Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

CC 0350

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300
Cincinnati, Ohio 45202
Phone: (513) 651-9300
Fax: (513) 352-1345

September 2, 1994

Rex Ralph Elementary
Attn: School Records
1310 Adams Road
Cincinnati, Ohio 45215

728-4685

RE: Lee Edward Moore DOB: 10-19-74

TO WHOM IT MAY CONCERN:

Enclosed is a signed Authorization for Release of Information form regarding the above-named person.

Our agency is under a very strict time-frame to provide a comprehensive report to the Court, therefore, we would greatly appreciate information from you as soon as possible.

Thank you in advance for your prompt and courteous attention to this matter.

Sincerely,

Jenny O'Donnell

Jenny O'Donnell, B.S.
Psychology Trainee

CC 0351

CENTRAL PSYCHIATRIC CLINIC
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON Rex Ralph Elementary in Mt Healthy

ADDRESS 1310 Adams Rd.; (15)

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR _____

The following information may be released or reviewed:

( ) Discharge Summary
( ) Face Sheet with Final Diagnosis
( ) Complications & Operative Procedures
( ) History and Physical
( ) Consultative Report(s)
( ) Inpatient ( ) Outpatient

( ) Reports of Tests or X-rays
( ) Emergency Treatment(s)
( ) Outpatient Clinic Notes
Specify Clinic _____
(✓) Other All Records
( ) Emergency Department

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I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Moore (M.I. Edward) Lee E. Moore Jr
(Signature of Client)

Date of Birth 10-19-74

Social Security No. 284-74-1946 9-1-94
(Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell
Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by _____
(Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

CC 0352

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER

A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300
Cincinnati, Ohio 45202
Phone: (513) 651-9300
Fax: (513) 352-1345

September 2, 1994

Mt. Healthy High School
Attn: Records
2046 Adams Road
Cincinnati, Ohio 45231

729-0130

RE: Lee Edward Moore DOB: 10-19-74

TO WHOM IT MAY CONCERN:

Enclosed is a signed Authorization for Release of Information form regarding the above-named person.

Our agency is under a very strict time-frame to provide a comprehensive report to the Court, therefore, we would greatly appreciate information from you as soon as possible.

Thank you in advance for your prompt and courteous attention to this matter.

Sincerely,

Jenny O'Donnell/JP

Jenny O'Donnell, B.S.
Psychology Trainee

CC 0353

CENTRAL PSYCHIATRIC CLINIC
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON Mt Healthy High School Attn: Records

ADDRESS 2046 Adams Rd.; 31

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR _____

The following information may be released or reviewed:

( ) Discharge Summary
( ) Face Sheet with Final Diagnosis
( ) Complications & Operative Procedures
( ) History and Physical
( ) Consultative Report(s)
( ) Inpatient ( ) Outpatient

( ) Reports of Tests or X-rays
( ) Emergency Treatment(s)
( ) Outpatient Clinic Notes
Specify Clinic: _____
(✓) Other ALL Records
( ) Emergency Department

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I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Moore Middle (Edward) Lee E. Moore JM
(Signature of Client)

Date of Birth 10-19-74

Social Security No. 284-74-1946 9-1-94
(Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell
Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by _____
(Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

CC 0354

CENTRAL PSYCHIATRIC CLI
COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202
513-651-9300

I, the undersigned, hereby authorize the Community Diagnostic and Treatment Center to release/obtain information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV). All matters pertaining to client records are considered privileged and confidential and are treated as such by the employees of the program. Information regarding such matters cannot be given without the consent of the client. PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON HCJC Intake Records

ADDRESS _____

PURPOSE/NEED FOR DISCLOSURE of information between Community Diagnostic and Treatment Center and the agency/person named above: Aid in court-ordered evaluation/treatment of the person named below. OR _____

The following information may be released or reviewed:

( ) Discharge Summary
( ) Face Sheet with Final Diagnosis
( ) Complications & Operative Procedures
( ) History and Physical
( ) Consultative Report(s)
( ) Inpatient ( ) Outpatient
( ) Reports of Tests or X-rays
( ) Emergency Treatment(s)
( ) Outpatient Clinic Notes
Specify Clinic: MHtl & Intake
(✓) Other All Records
( ) Emergency Department

This Authorization for Release of Information may be revoked by me at any time with written notice to the parties involved, except to the extent action has been taken prior to revocation. This Authorization for Release of Information will expire ninety (90) days after date below, or sooner by my choice, in which case this consent will expire on _____.

I hereby acknowledge that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the records to the purpose and extent stated above.

FULL NAME OF CLIENT Lee Moore X Lee E. Moore Jr. (Signature of Client)

Date of Birth 10-19-74

Social Security No. 284-74-1946 9-1-94 (Date)

PLEASE FORWARD REQUESTED INFORMATION TO: Jenny O'Donnell / DAVE CHIAPPONE
Community Diagnostic and Treatment Center, 909 Sycamore Street, Suites 300 and 400, Cincinnati, OH 45202.

This authorization was facilitated by _____ (Staff member's signature)

Date 9-1-94

c: To be retained in Client Record

CC 0355

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
909 Sycamore Street
Cincinnati, Ohio 45202

Receipt Confirmation

This section must be read aloud to all clients by a Community Diagnostic and Treatment Center staff person to the client/legal guardian signing below.

I have been given and read a copy of this document, Client's Responsibilities and Rights Policy. I understand its contents. At my request, should I desire, this entire document will be read to me aloud and all questions regarding its contents will be answered, to the extent possible.

Gee E. Moore Jr. — Client/Legal Guardian — 9-1-94 — Date

Jenny O'Donnell — Community Diagnostic & Tx. Center — 9-1-94 — Date

cc: Client's File

TO: Clients of the Court Psychiatric Center

FROM: Center Staff

You have been referred to our Center by Judge Morrissey who is asking us to see you in order to help make some decisions about your situation. After you have talked with staff members, a report will be written to the person(s) who referred you to our Center.

You have the right to choose not to speak with our staff. If you begin the interview, you have the right to stop the interview at any time. You also have the right to discuss this evaluation with your attorney. If you decide not to talk to us, or if you miss your appointment, we will have to include this in our report.

Sometimes the person who referred you is asking us to talk with you to see if you are having any problems which may have led to your arrest. If we find that you could benefit from help for such problems, we will make this recommendation to the person who referred you. If the Judge, probation officer or parole officer decides that you should get this help, we will assist you in arranging for the services, either in our clinic or in the community. We will not send our reports to any treatment agency in the community without your written permission.

Your signature below indicates that you understand this statement.

Joe E. Moore Jr.

Client

9-1-94

Date

COMMUNITY DIAGNOSTIC AND TREATMENT CENTER

A Division of Central Psychiatric Clinic

909 Sycamore Street, Suite 300
Cincinnati, Ohio 45202
Phone: (513) 651-9300
Fax: (513) 352-1345

May 23, 1994

The Honorable William J. Morrissey
Hamilton County Court of Common Pleas
Cincinnati, Ohio 45202

RE: LEE MOORE
DOC.#: B94-00481

Dear Judge Morrissey:

Following the conversation between yourself, Sherry Sanders and myself last week regarding the appointment of a mitigation specialist in the case of Lee Moore, I have reviewed the motion you provided to me and have spoken with Dan James, defense attorney on the case. It is my understanding that the motion is requesting the appointment of a mitigation specialist, it is not a request for psychological-psychiatric evaluation. A mitigation specialist has training and expertise that our clinic does not possess. Consequently, our clinic would not be an appropriate appointment as a mitigation specialist on this case. If the court or defense counsel are considering appointment of our clinic to perform a psychological-psychiatric evaluation in this matter, we would request that the appointment be made as soon as possible. Customarily, it will take four to six weeks to collect the appropriate school and medical records, make contact with family members, perform psychological testing, and request any other additional specialty evaluations.

Respectfully submitted,

Nancy Schmidtgoessling, Ph.D.
Director

NS/vle

CC 0358

COURT OF COMMON PLEAS
CRIMINAL DIVISION
HAMILTON COUNTY, OHIO

STATE OF OHIO	:	Case No. B9400481
		Judge Morrissey
Plaintiff	:	
vs.	:	MOTION FOR APPOINTMENT OF MITIGATION SPECIALIST AT PUBLIC EXPENSE
LEE MOORE	:	
Defendant	:	

Now comes LEE MOORE, by and through counsel, and moves the Court for an order appointing a mitigation specialist. The reasons in support of this motion are set out in the accompanying Memorandum in Support. Furthermore, Defendant, being indigent, requests that said services be paid at public expense.

Respectfully submitted,

Daniel J. James #0008067
30 E. Central Parkway
1300 American Building
Cincinnati, Ohio 45202
(513) 721-1995

and

Timothy J. Deardorff #0006308
2368 Victory Parkway
Suite 300
Cincinnati, Ohio 45206
(513) 872-7900

Attorneys for Defendant

MEMORANDUM IN SUPPORT

LEE MOORE is an indigent who stands before this Court charged with Aggravated Murder with death penalty specifications. In light of the severity of the possible sentence, the State has a substantially increased interest in assuring the reliability of the fact-finding process and the propriety of the sentence to be imposed. In order to guarantee that any sentence which is imposed is appropriate in this case, it is essential that defense counsel be provided with the expert assistance of a mitigation specialist.

The Sixth and Fourteenth Amendments to the United States Constitution guarantee the accused the right to the assistance of counsel. The United States Supreme court has recognized that this right to counsel is a right to effective aid of counsel. Powell vs. Alabama (1932), 287 U.S.45, 77 L. Ed. 457, 53 S. Ct. 55; Gideon vs. Wainwright (1963), 372 U.S. 9 L. Ed., 2d 799, 83 S. Ct., 792. Further, the Sixth Amendment assures the Defendant the right to compulsory process, which includes the "right to present the defendant's version of the fact." Washington vs. Texas (1967), 388 U. W. 14, 19. Additionally, the Defendant is entitled to a "fair and adequate opportunity" to defend against expert testimony under the Fourteenth Amendment due process, Chambers vs. Mississippi (1973), 410 U.S. 284, 294, 302, and equal protection clauses, Ross vs. Moffitt (1974), 417 U.S. 600, 616. "Moreover, adequate representation includes thoroughgoing investigation and